

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0546

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harvey de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>	
TOWN <u>Harford Memorial Hosp.</u>		TOWN <u>Port Deposit</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp.</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>(First) Margaret (Middle) Katherine (Last) BANNON</u>		4. DATE OF DEATH <u>JANUARY 12 1951</u> (Month) (Day) (Year)	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>JANUARY 8 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>4</u> yrs. If under 1 year: Months Days Hours Min.
11. FATHER'S NAME <u>Norman J. Bannon Jr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Edith Marie Narvel</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Norman Bannon Sr., Port Deposit.</u>		18. MEDICAL CERTIFICATION <u>Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ImmaturityAntecedent cause(s) (b) 159

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1.12, 1951, to 1.12, 1951, that I last saw the deceased alive on 1.12, 1951, and that death occurred at 1:45 p.m., from the causes and on the date stated above.

SIGNATURE

Alexander Sandecki MD

(Degree or title)

ADDRESS

Harvey de Grace Md

DATE SIGNED

1.12.51

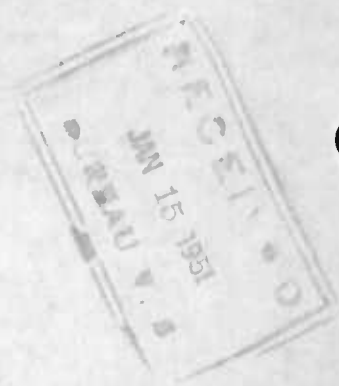
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>		DATE THEREOF <u>1-13-1951</u>		NAME OF CEMETERY OR CREMATORY <u>Harmony Chapel</u>		LOCATION (City, town, or county) (State) <u>Rowlandville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 13-1951</u>		REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>		24. FUNERAL DIRECTOR <u>W. A. Patterson & Son.</u>		ADDRESS <u>Perryville, Md.</u>	

201081191280

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH- COUNTY <u>Harford</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Aberdeen</u>		LENGTH OF STAY (in this place) <u>10 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Aberdeen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>38 Laft. St.</u>				STREET ADDRESS <u>38 Laft. St.</u> (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>William Henry</u>		(First) (Middle) (Last)		4. DATE OF DEATH <u>Jan. 13 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 1902</u>	9. AGE last birthday <u>48</u> yrs.	If under 1 year If under 24 hrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harbor operator - Labor Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.P.B. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
13. FATHER'S NAME <u>Wm. Henry Baubitz</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT <u>Mrs. Eva May Baubitz</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION</u>			
93d Antecedent cause(s) (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 12, 1951, to Jan. 13, 1951, that I last saw the deceased
alive on Jan. 13, 1951, and that death occurred at 10:10 P.m., from the causes and on the date stated above.

SIGNATURE J. W. Ramsey (Degree or title) 21. D. ADDRESS Aberdeen, Md. DATE SIGNED Jan 14, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Jan. 17 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		LOCATION (City, town, or county) <u>Harford Co. Md.</u>		(State)	
DATE REC'D BY LOCAL REG. <u>Jan. 15-1951</u>		REGISTRAR'S SIGNATURE <u>Nellie A. Wiley</u>		24. FUNERAL DIRECTOR <u>H. Madison Mitchell</u>		ADDRESS <u>Harford Co. Md.</u>			

683 916 Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

0548

1. PLACE OF DEATH:

County HARFORD.City or town BEL AIR.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 YEARS.Hospital, institution, or street address where death occurred: —How long in hospital or institution? —

3. (a) FULL NAME

NELSON B. BOLL

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W.

6. (b) Name of husband or wife

UNKNOWN.

7. Birth date of deceased (mo., day, yr.)

APRIL 4 18846. (c) If alive, give age — years

8. AGE:

66927

If less than one day

hrs.

min.

9. Birthplace

UNKNOWN

(Town, county, and state)

10. Usual occupation

CLERK

11. Industry or business

CLOTHING STORE

FATHER

12. Name

UNKNOWN

13. Birthplace

UNKNOWN.

14. Maiden name

15. Birthplace

16. Informant

H. P. Sidwell M.D.

Address

Bel Air, Md.

17.

burial
(Burial, cremation, or removal. Which?)Date thereof Sept 2/51
(month) (day) (year)

Cemetery or crematory

Bel Air Memorial Garden

Location

Bel Air Md

18. Funeral director

Jos. J. Foster

Address

Bel Air Md

19.

not on joint copy
(Date rec'd by registrar)

19

Priscilla J. Foster
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HARFORD.City or town BEL AIR.
(If outside city or town limits, write RURAL and give nearest town)Street No. VAUGHN APT'S MAIN ST.
(If rural, give LOCATION)2. (a) If veteran, name war —

3. (b) Social Security Number

196-18-6746

MEDICAL CERTIFICATION

20. DATE OF DEATH 31 JAN 1951 at 2:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

13 SEPT 1948 to 31 JAN 1951and that I last saw him alive on 31 JAN 1951.

Immediate cause of death

PULMONARY EDEMA.

DURATION

1 HOUR.Due to ARTERIO-SCLEROTICCARDIO-VASCULAR DISEASE3 YRS.Due to HYPERTENSIONOR MORE.

Other conditions

443x93d

(Include pregnancy within 3 months of death)

Major findings of operations

NONEDate of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? —
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —

23. SIGNATURE

H. P. Sidwell M.D.

M. D. or other

Address Bel Air, Md Date signed 31 Jan 51
370656

84078
FEB 2 1951
U.S. AIR FORCE

0549 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake Rural</u> TOWN <u>Chesapeake Rural</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>50 years</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake Rural</u> TOWN <u>Chesapeake Rural</u> STREET ADDRESS (If rural, give location) <u>Bush Chapel Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) <u>Anna</u> (Middle) <u>Braunson</u> (Last)		4. DATE OF DEATH <u>Jan</u> (Month) <u>1st</u> (Day) <u>1951</u> (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 8th 1880</u>	9. AGE last birthday <u>70</u> yrs.	If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Charles Williams</u>		14. MOTHER'S M maiden NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <u>Gonzal C. Braunson</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <u>Cerebral Thrombosis</u>		72 hr.	
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Cerebral Arteriosclerosis</u>		10 yr.	
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None other than Senility</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE <u>No</u> (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan 31 1951</u>		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 12/31/50, 1950, to 1/1/51, 1951, that I last saw the deceased alive on 12/30, 1950, and that death occurred at 10:00 P.m., from the causes and on the date stated above.

SIGNATURE <u>W. V. Hoffman, M.D.</u>		ADDRESS <u>Chesapeake, Md.</u>		DATE SIGNED <u>1-2-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan 5th 51</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary Cemetery</u>	
LOCATION (City, town, or county) <u>Chesapeake Harford Co. Md.</u>		(State) <u>Md.</u>			
DATE REC'D BY LOCAL REG. <u>Jan. 5-1951</u>		REGISTRAR'S SIGNATURE <u>Helene Z. Wiley</u>		24. FUNERAL DIRECTOR <u>Henry Tarrington and Sons Chesapeake Md.</u>	

MARGIN RESERVED FOR BINDING

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180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE
ON THIS SIDE
OF THE
PAGE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0551

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Abertdeen</u> LENGTH OF STAY (in this place) <u>7 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Abertdeen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Abertdeen Ave. Extended</u>		STREET ADDRESS (If rural, give location) <u>Belair Ave. Extended</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elizabeth</u> (Middle) <u>Bellingu</u> (Last) <u>Carlisle</u>	4. DATE OF DEATH	(Month) <u>Jan.</u> (Day) <u>26</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>June 4, 1880</u> 9. AGE last birthday <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Bellingu</u>		14. MOTHER'S MAIDEN NAME <u>C. A. Elizabeth Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>—</u>	
(If year, give war or dates of service)		17. INFORMANT, AND ADDRESS <u>Mrs. Edna C. White</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Pulmonary Edema</u>		<u>Terminal</u>
174X Antecedent cause(s)	(b) <u>Arteriosclerotic Heart Disease</u>		<u>2 mo.</u>
482 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Adenocarcinoma of Uterus & Metastases</u>		<u>4 1/2 mo.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>9-28-50</u>	19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma of Uterus with parametrial extension</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10-1, 1950, to 1-26, 1951, that I last saw the deceased alive on 1-26, 1951, and that death occurred at 12:15 m., from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>Jan. 29, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Mr. Geon</u>	LOCATION (City, town, or county) <u>Harford Co.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 29, 1951</u>	REGISTRAR'S SIGNATURE <u>Hellie H. Riley</u>	24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>		ADDRESS <u>Lavada Gaer Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

Evidence for change
in 8 shown on:

2411 N. Charles Street, Baltimore

0552

CERTIFICATE OF DEATH

Reg. Dist. No. 181

FILM No. G 130 FEB 1 1951

1. PLACE OF DEATH- COUNTY Harford MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) Aberdeen		CITY (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Army Hospital Aberdeen Proving Ground		STREET ADDRESS (If rural, give location) Apt #2 Quarters 948	
3. NAME OF DECEASED (First) BEN (Middle) W. (Last) CHIPMAN	4. DATE OF DEATH (Month) January (Day) 15 (Year) 1951		
5. SEX Male	6. COLOR OR RACE White	7. KNOCK MARRIED WIDOWED WIDOWED (Specify) Married	8. DATE OF BIRTH 29 Nov 1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - M/Sgt		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army-	9. AGE last birthday 42 yrs. If under 1 year Months Days Hours Mln.
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Anna Price	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Current		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Personnel Section - Hq, APG, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) *arteriosclerosis of myocardium due to thrombosis of coronary artery*

(b) *Arteriosclerotic heart disease*

(c)

INTERVAL BETWEEN ONSET AND DEATH

10 minutes

2 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
12042		
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)		
SUICIDE HOMICIDE none		
INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 Jan, 1951, to 15 Jan, 1951, that I last saw the deceased

alive on 14 Jan, 1951, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

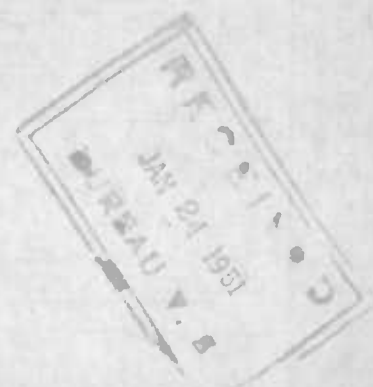
SIGNATURE *Murray S. Apple* (Degree or title) ADDRESS *US Army Hqs. Aberdeen Proving Ground* DATE SIGNED *15 Jan 51*

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan 17, 1951	National	Arlington, Va.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 22-1951	<i>Ellie S. Riley</i>	<i>Howard K. McBurney & Son</i>	<i>Aberdeen, Md. 595-916</i>

MARGIN RESERVED FOR BINDING

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VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

0553

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Perryman, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryman, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Aberdeen Post Office</u>		STREET ADDRESS (If rural, give location) <u>Aberdeen Post Office</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Solomon</u>	(Middle) <u>Benjamin</u>	(Last) <u>Christy</u>
4. DATE OF DEATH	(Month) <u>1</u>	(Day) <u>13</u>	(Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 4, 1877</u>
9. AGE last birthday <u>73</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Perryman, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob C. Christy</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Reed</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Christy - Aberdeen Post Office, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Haemorrhage from Esophageal Varices

INTERVAL BETWEEN ONSET AND DEATH

36 hr.

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Esophageal Varices1 yr.

(c)

Chronic Passive Congestion of Liver2 yr.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Severe Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-15, 1950, to 1-13, 1951, that I last saw the deceased alive on 1-13, 1951, and that death occurred at 6:10 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 16-1951Hellie B. RileyEmory E. BullockHarrods Green, Md.

970246

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-0554

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>		STREET ADDRESS (If rural, give location) <u>339 STRAWBERRY</u>	
3. NAME OF DECEASED (Type or Print) <u>William G. Christy</u>		4. DATE OF DEATH <u>JAN. 16, 1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MARCH 1, 1949</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PERCY Christy</u>		14. MOTHER'S MAIDEN NAME <u>ERNESTINE Starling</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT AND ADDRESS <u>Hospital Records</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4912 Immediate cause (a) Bronchopneumonia108 Antecedent cause(s) (b) Dehydration.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from JAN. 15, 1951, to JAN. 16, 1951, that I last saw the deceased alive on JAN. 16, 1951, and that death occurred at 3:55 A.M., from the causes and on the date stated above.

SIGNATURE

Charles J. Badellano M.D.

ADDRESS

Harford Memorial Hosp. 1-1651

23. BURIAL, CREMATION OR DISPOSAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

(DATE REC'D BY LOCAL REG.)

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

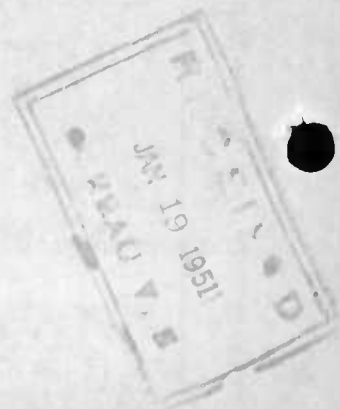
ADDRESS

Jan. 17-1951G. L. Lewis M.D.Cunningham & SonHarford County, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

0555

1. PLACE OF DEATH- COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Alberdeen</u> TOWN <u>Alberdeen</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Post Road - ext.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Alberdeen</u> TOWN <u>Alberdeen</u> STREET ADDRESS (If rural, give location) <u>Post Road - ext.</u>	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>G.</u> (Middle) <u>Christy</u> (Last)	4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>16</u> (Year) <u>1951</u>	5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Oct. 17 1900</u>	9. AGE last birthday <u>50</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ray Tobacco</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Robt. L. Christy</u>	14. MOTHER'S MAIDEN NAME <u>Sarah Christy</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY No. <u>1-19-51</u>	17. INFORMANT AND ADDRESS <u>Lizette R. Christy - Alberdeen MD 2nd</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Azotemia</u>	INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>
Antecedent cause(s) (b) <u>Nephrosclerosis</u>	<u>5 yr.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerosis</u>	<u>5 yr.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arter. Fibrillation</u>	<u>1 yr.</u>

19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>No</u>	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-15 1950 to 1-16 1951, that I last saw the deceased alive on 1-15 1950, and that death occurred at 5:30 AM from the causes and on the date stated above.

SIGNATURE <u>Walter P. Rodman, M.D.</u>	DATE SIGNED <u>1-19-51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 19 1951</u>
NAME OF CEMETERY OR CREMATORY <u>Union M. L. Cemetery</u>	LOCATION (City, town, or county) (State) <u>Alberdeen Harford Co. Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 19-1951</u>	24. FUNERAL DIRECTOR ADDRESS <u>Henry J. Youngman, Chambers</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970 VVV



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

0556

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Scarbors</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Scarbors</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Wm. H. Day</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>31</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>August 7, 1893</u> 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Edgewood Ordnance Plant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Edgewood Ordnance Plant</u>	
11. FATHER'S NAME <u>Wm. H. Day</u>		12. MOTHER'S MAIDEN NAME <u>Eliza Bannister</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>216-05-8179</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Wm. H. Day</u> <u>Street, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>metastatic carcinoma</u>		<u>6 mo.</u>	
Antecedent cause(s) (b) <u>Carcinoma of Stomach</u>		<u>2 1/2 yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>none</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>			
19a. DATE OF OPERATION <u>Nov. 13, 1950</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of cardia of stomach.</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug.</u> , 19 <u>48</u> , to <u>Jan. 31, 1951</u> , that I last saw the deceased alive on <u>Jan. 30, 1951</u> , and that death occurred at <u>2:35</u> P.m., from the causes and on the date stated above.			
SIGNATURE <u>Charles C. Huff M.D.</u>		ADDRESS <u>Street, Md.</u> DATE SIGNED <u>2-1-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 4, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Harford Co. Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>Feb. 4, 1951</u>		REGISTER'S SIGNATURE <u>C. H. Kirk</u>	
FUNERAL DIRECTOR <u>H. S. Bailey</u>		ADDRESS <u>Harlington Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

970416

RECEIVED
FEB 9 1991
FBI

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0557

185

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harre de Grace</u> LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lorraine Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u>		STREET ADDRESS (If rural give location) <u>6910 Penway</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>SIMON</u> (First) <u>P.</u> (Middle) <u>Decmer</u> (Last)	4. DATE OF DEATH <u>1</u> (Month) <u>29</u> (Day) <u>1957</u> (Year)		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3-5-71</u>
9. AGE last birthday <u>79</u> yrs.	If under 1 year Months Days	If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor foreman Beth Steel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>214-10-0156</u>	
		17. INFORMANT <u>Mrs. Alla Rogers, 6910 Penway</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

902.7 Immediate cause
 186a Antecedent cause(s)
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) Fracture R. femur

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 day

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerotic C.V. disease

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Harford convalescent Home</u>	(CITY OR TOWN) <u>Beth A in Harford</u>	(COUNTY) <u>md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Jan 29 1957</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fell out of bed</u>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald C Palmer M.D. Deputy Medical Examiner Harford Co. Beth A in md. 11/29/57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATOR	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>2/1/57</u>	<u>Oak Lawn</u>	<u>Baltimore, Maryland</u>

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/31/57</u>	<u>W.A. Hedrick</u>	<u>Wm. Cook, Inc., 1217 E. Paul St.</u>	

523336

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0558

Reg. Dist. No. 182

1. PLACE OF DEATH - COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Edna</u> (Middle) <u>Belle</u> (Last) <u>Eckman</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug. 16 - 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>73</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Chester Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Clarence Hamilton, Whiteford, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Third Degree Burns Entire Body
 Antecedent cause(s) (b) Senile Dementia
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH
none

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Home</u>	(CITY OR TOWN) <u>Whiteford</u> (COUNTY) <u>Harford</u> (STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>January 7, 1951</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>House caught fire & burned her up</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald C Palmer MD Deputy Medical Examiner Harford County Bldg or MD 1/7/51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 9 - 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Tabernacle cem.</u>	LOCATION (City, town, or county) <u>Whiteford, Md.</u>
DATE RECD BY LOCAL REG. <u>1/9/51</u>	REGISTRAR'S SIGNATURE <u>Priscilla Lowwood</u>	24. FUNERAL DIRECTOR <u>Hubert P. Harkins</u>	ADDRESS <u>Delts, Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0559 180

1. PLACE OF DEATH- COUNTY HARFORD		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN EDGEWOOD		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN WHERRY QUARTERS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. ARMY DISPENSARY ARMY CHEMICAL CENTER, MD.		STREET ADDRESS (If rural give location) ARMY CHEMICAL CENTER	
3. NAME OF DECEASED (First) GRADY	(Middle) MILTON	(Last) EVANS	4. DATE OF DEATH (Month) JAN (Day) 28 (Year) 19 51
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH 6 JAN 1920
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	9. AGE last birthday 31 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) LOMETA, TEXAS		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH DONALD EVANS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) at present		16. XXXXXX ASN: 01036965	
17. INFORMANT Records, Army Chemical Center Md			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) ACUTE ALCOHOLISM		
Antecedent cause(s) (b) 322.0		
Diseases or conditions, if any, giving rise to the above cause atating the underlying cause last (c) 77c		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify ~~that death occurred at 11:53 A.M. on January 29, 1951, from the causes and on the date stated above.~~

SIGNATURE **Gerald C Palmer** (Degree or title) ADDRESS DATE SIGNED

GERALD C. PALMER, MD, Deputy Medical Examiner, Harford County, Bel Air, Md. 29 JAN 1951

23. BURIAL, CREMATION DATE REMOVAL (Specify)	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Jan 30, 1951	Bre ggs + Gamed 7.14. Gainsboro Texas	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Jan 30, 1951	Maureen M. Monds	Howard H. McConner & Son Abingdon Maryland 595916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY <u>Horford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>15 Essex Place</u> COUNTY <u>Horford</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Abbeville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Abbeville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Essex Place</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Allen Phillip</u> <u>Gough</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan</u> <u>5</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/7/1908</u>
9. AGE last birthday <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salisman</u>	
11. BIRTHPLACE (State or foreign country) <u>Waterbury, Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Gough</u>		14. MOTHER'S MAIDEN NAME <u>Edith Gough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>263-03-6041</u>	
17. INFORMANT <u>Jay V. Gough</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

970.2 Immediate cause (a) Barbiturate Poisoning (Suicidal)
 163B Antecedent cause(s) (b) Barbiturate Poisoning (Suicidal)
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. RURAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Cremation</u>	<u>Jan. 11, 1951</u>	<u>Greenmount</u>	<u>Baltimore</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Jan 10 - 1951</u>	<u>Nellie H. Riley</u>	<u>Henry Tarrington Sons</u>	<u>Abbeville, Md.</u>	

430 699

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 12 1951
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0561 185-

1. PLACE OF DEATH- COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Hayre de Grace</u> <u>50 yrs.</u> TOWN <u>Hayre de Grace</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> <u>Harford</u> <u>COUNTY</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hayre de Grace</u> TOWN <u>Hayre de Grace</u> STREET ADDRESS <u>556 Green</u> (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Emanuel</u> <u>Hecht</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1/27/51</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>7/23/1866</u>
9. AGE last birthday <u>84</u> yrs.		10. If under 1 year Months <u>6</u> Days <u>4</u> If under 24 hrs. Hours <u>4</u> Mio.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leibman Hecht</u>		14. MOTHER'S MAIDEN NAME <u>Hanna Simon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, oo, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>Jacob Hecht, 556 Green, Hayre de Grace, M</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Arterio Sclerosis</u>		
93d Antecedent cause(s) (b) <u>Cardio Vascular Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cachexia</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	(CITY OR TOWN) (COUNTY) (STATE)
HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 4/10/1947, to 1/27, 1951, that I last saw the deceased alive on 1/27, 1951, and that death occurred at 2:30 a.m., from the causes and on the date stated above.

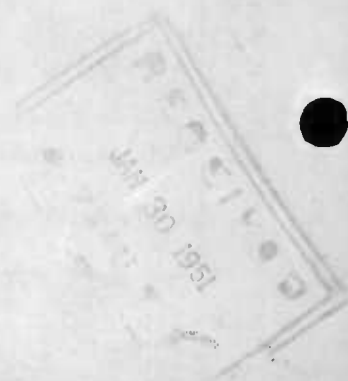
SIGNATURE <u>Charles J. Foley M.D.</u>	(Degree or title)	ADDRESS <u>700 O. Union. Ave</u>	DATE SIGNED <u>Jan 28/51</u>
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1/29/51</u>	NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan 28 1951</u>	REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	24. FUNERAL DIRECTOR <u>Pennington & Son</u>	ADDRESS <u>Hayre de Grace, Md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

290 686



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>10 yrs</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Jarrettsville</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Charles</u> (First) <u>-</u> (Middle) <u>Hess</u> (Last)		4. DATE OF DEATH <u>Jan 2</u> (Month) <u>2</u> (Day) <u>1957</u> (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>Dec 10, 1952</u>	9. AGE last birthday <u>98</u> yrs.	If under 1 year Months <u>0</u> Days <u>23</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Jarrettsville md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Henry Hess</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gross</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	17. INFORMANT AND ADDRESS <u>James C. M. Montgomery Jarrettsville md.</u>		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Natural Death - due to old age (98)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Arterio-sclerosis, generalized

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1947, to Dec 26, 1950, that I last saw the deceasedalive on Dec. 26, 1950, and that death occurred at 6:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 1-4-61

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0563 181

1. PLACE OF DEATH- COUNTY <u>Harcford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harcford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perryman</u>	
TOWN <u>Life Line</u>		TOWN <u>Perryman</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Fannie</u> (First) <u>N.</u> (Middle) <u>Holloway</u> (Last)		4. DATE OF DEATH <u>Jan.</u> (Month) <u>25</u> (Day) <u>1951</u> (Year)	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 19, 1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Michael</u>		14. MOTHER'S MAIDEN NAME <u>Susanna Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mr. Frank J. Holloway</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause (a) <u>Chronic Myocarditis</u>		
93d Antecedent cause(s) (b) <u></u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 2, 1950, to Jan. 25, 1951, that I last saw the deceased alive on Jan. 25, 1951, and that death occurred at 9:45 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) H. S. Holloway ADDRESS Perryman, Md. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan. 27, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Shepherd's</u>	LOCATION (City, town, or county) <u>Perryman</u>	(State) <u>md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 26-51</u>	REGISTRAR'S SIGNATURE <u>Nellie B. Riley</u>	24. FUNERAL DIRECTOR <u>Henry Tarrington</u>	ADDRESS <u>Aberdeen</u>	<u>md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JAN 29 1961
FBI - NEW YORK

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition MARYLAND STATE DEPARTMENT OF HEALTH
in 18 shown on:

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 181

FILM No. G 150 FEB 6 1951

1. PLACE OF DEATH - COUNTY Harford Harford MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland Maryland COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) Aberdeen - Route 40		CITY (If outside corporate limits, write RURAL and give nearest town) Perryman	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) OMAR	(Last) HOOPS
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Dec 9, 1922
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U.S. Army	9. AGE last birthday 28 yrs. If under 1 year Months Days Hours Min.
11a. BIRTHPLACE (State or foreign country) Unknown Tenn.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown William L. Hooper		14. MOTHER'S MAIDEN NAME Unknown Mrs L. Doak	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Current		16. SOCIAL SECURITY No. 215-12-1830	
17. INFORMANT Maryland State Police - Personnel Cards			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Fracture Skull, compound

INTERVAL BETWEEN ONSET AND DEATH

none

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Auto accident (2-6-51 - ans)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing in the death but not related to the disease or condition causing death.

(c) Fracture R clavicle, R mandible, and nose

none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office, etc.) INJURY IN Route 40

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Jan 27, 1951 m.

INJURY OCCURRED While at work Nnt while at work

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald C Palmer M.D. Deputy Medical Examiner Harford Co. Bel Air Md 1/27/51

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

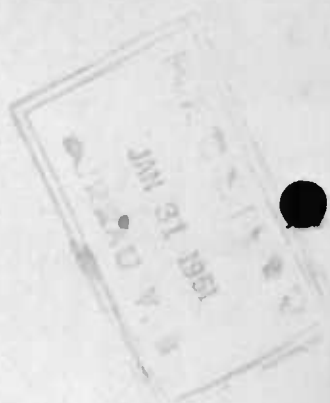
24. FUNERAL DIRECTOR

ADDRESS

Jan 30 - 1951 Nellie R. Riley

Perryman Harford Co. Bel Air Md

595916 Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

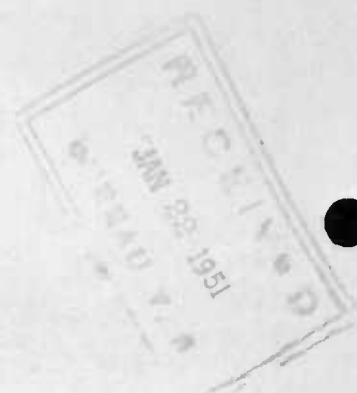
FOR MEDICAL EXAMINERS

0565

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <i>Harford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i> COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Bel Air Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>Charles A Jackson</i>		4. DATE OF DEATH (Month) <i>January</i> (Day) <i>16</i> (Year) <i>1951</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>May 4/1892</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	9. AGE last birthday <i>58</i> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <i>Elkton Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Armstrong Jackson</i>		14. MOTHER'S MAIDEN NAME <i>Harnett Racine</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Ruth J Reynolds Pylesville Md</i>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
976x Immediate cause (a) <i>Gunshot wound left chest</i>			<i>none</i>
164c Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <i>Bel Air Harford Md</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Jan 16, 1951 7p</i>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? <i>shot self with shotgun</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE (Degree or title) <i>Herold C Palmer M.D. Deputy Medical Examiner Harford Co.</i>		DATE SIGNED <i>1/16/51</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Jan 20/51</i>	
NAME OF CEMETERY OR CREMATORY <i>Elkton Cemetery</i>		LOCATION (City, town, or county) (State) <i>Bel Air Md</i>	
DATE REC'D BY LOCAL REG. <i>1/18/51</i>		24. FUNERAL DIRECTOR <i>Joseph J. Foster Bel Air Md</i>	

840105



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0566

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY <u>Hartford</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Havre Grace MD #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Ruth Elizabeth Jenkins</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 19-1930</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Chemical Center</u>	9. AGE last birthday <u>20</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Andrew E. Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Sarah M. Roe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Herman M. Thomas</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary occlusion</u>		<u>4 hrs</u>
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE (Degree or title) Donald C. Palmer MD ADDRESS Deputy Medical Examiner Hartford Co. Bldg. in Md. 10/6/51 DATE SIGNED 10/6/51

23. BURIAL, CREMATION OR MOV. (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 11th 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Havre Grace, Harford, Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan 10-1951</u>	REGISTRAR'S SIGNATURE <u>Hellie E. Wiley</u>	24. FUNERAL DIRECTOR <u>Henry Tarring</u>	ADDRESS <u>Ed Sous, Chesapeake Maryland</u>

350916

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> LENGTH OF STAY (in this place) <u>all his life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>136 Baltimore St.</u>		STREET ADDRESS (If rural, give location) <u>136 Baltimore St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Hannah</u> (Middle) <u>Lee</u> (Last) <u>Lee</u>	4. DATE OF DEATH	(Month) <u>1</u> (Day) <u>1</u> (Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Sept 24 1883</u>
9. AGE last birthday <u>67</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Housemaid</u>	11. BIRTHPLACE (State or foreign country) <u>Harford County - Rock Run, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	13. FATHER'S NAME <u>Lidney Lee</u>	14. MOTHER'S MAIDEN NAME <u>Mary Peaco</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>X</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY No. <u>X</u>	17. INFORMANT AND ADDRESS <u>Mrs. Laura Morsey, 136 Balt. St. Aberdeen, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(a)

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐

22. I hereby certify that I attended the deceased from 12/13, 1950, to 1/1, 1951, that I last saw the deceased

alive on 12/31, 1950, and that death occurred at 8:25 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 3-1951

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

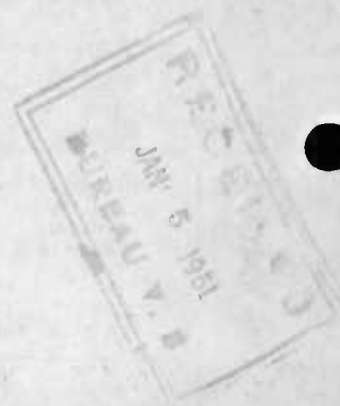
ADDRESS

720826

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change
in 8 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0568

FILE No. G 130 FEB 14 1957 **CERTIFICATE OF DEATH**

Reg. Dist. No. 182

1. PLACE OF DEATH- COUNTY <u>Holmdel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Holmdel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pylesville</u> 19.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pylesville Rd.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>CYNTHIA C LINKOUS</u>		4. DATE OF DEATH <u>Jan 31 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 12 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>82</u> yrs.
13. FATHER'S NAME <u>John & Sarah</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No. <u>none</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Sparks</u>	
17. INFORMANT AND ADDRESS <u>Thomas P Linkous Pylesville md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>5 Mins?</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
181x Immediate cause (a) <u>Carcinoma of Bladder</u>		
Antecedent cause(s) (b) <u>52x Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>		
II. OTHER SIGNIFICANT CONDITIONS (c) <u>Chronic Myocarditis</u>		
19a. DATE OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION		
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1950, to Jan 30 1951, that I last saw the deceased alive on Jan 30, 1951, and that death occurred at 1 P.M., from the causes and on the date stated above.

SIGNATURE <u>Edward H. Hyson</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Fawn Grove, Pa.</u>	DATE SIGNED <u>1/31/51</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>Feb 3 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Fawn Grove</u>	LOCATION (City, town, or county) (State) <u>Pd</u>
DATE REC'D BY LOCAL REG <u>Feb 1 51</u>	REGISTRAR'S SIGNATURE <u>Maxilla Lowndes</u>	24. FUNERAL DIRECTOR <u>Howard Webb Fawn Grove Pd</u>	ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>HARFORD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ABERDEEN</u> 36122		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>EDGEWOOD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. ARMY HOSPITAL</u> <u>ABERDEEN TRAINING GROUND</u>		STREET ADDRESS (If rural, give location) <u>ARMY CHEMICAL CENTER</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARTIN - BABY GIRL</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 19 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JANUARY 18, 1951</u>
9. AGE last birthday <u>36</u> yrs.		10. If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>RICHARD HOUGHTON MARTIN</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH PUCETTI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Sgt. Richard A. Martin</u> <u>2800 MC. TEST ST. ARMY CHEMICAL CENTER, Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u>
Immediate cause (a) <u>Respiratory Failure</u>			
Antecedent cause(s) (b) <u>Prematurity</u>			
159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>—</u>	

22. I hereby certify that I attended the deceased from 18 Jan., 1951, to 19 Jan., 1951, that I last saw the deceased alive on 19 Jan., 1951, and that death occurred at 8:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE <u>Jan 23, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	LOCATION (City, town, or county) (State) <u>Aberdeen Training Ground Md</u>
DATE REC'D BY LOCAL REG. <u>Jan 26 - 51</u>		REGISTRAR'S SIGNATURE <u>William H. Riley</u>		24. FUNERAL DIRECTOR <u>Howard C. McCreary</u>
				ADDRESS <u>Aberdeen Md</u>

201081201250

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 29 1951
SPECIAL

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0570

Reg. Dist. No. 181

1. PLACE OF DEATH- COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>5 months</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> STREET ADDRESS (If rural, give location) <u>104 Rodman St.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>PATRICK</u> <u>F</u> <u>Martin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January</u> <u>18</u> <u>1951</u>		5. SEX <u>male</u>	
6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Aug 6th 1904</u>	
9. AGE last birthday <u>46</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. & Rental Bldg. Apartment Houses</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Mr. Patrick F. Martin Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret D. Dodman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>J. Bradley Martin</u>					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

5 mi

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Levold C Palmer MD Deputy Medical Examiner Harford Co. B&A in Md 1/19/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 19-1951 Mellie A. Riley

Henry Tarrington Sons Aberdeen

470 746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUN 22 1951
U.S. DEPT. OF AGRICULTURE
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hosp.</u>		STREET ADDRESS (If rural, give location) <u>742 Ontario</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>ELMER</u> (Middle) <u>McCommons</u> (Last)		4. DATE OF DEATH <u>JANUARY 19</u> 19 <u>51</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>Aug. 8, 1898</u>
9. AGE last birthday <u>52</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>ABERDEEN PROVING Ground</u>	
12. FATHER'S NAME <u>CHARLES E. McCommons</u>		13. MOTHER'S MAIDEN NAME <u>Nannie M. Ward</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		15. SOCIAL SECURITY No. <u>Mr. D. B. Lynch, Pungent, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Pneumonia (Left)</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Pulmonary infarct (x)</u>		
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 15, 1951, to Jan. 19, 1951, that I last saw the deceased alive on Jan. 18, 1951, and that death occurred at 12:45 a.m., from the causes and on the date stated above.

SIGNATURE A. L. Lewis M.D. (Degree or title) ADDRESS Harford, Md. DATE SIGNED Jan. 19, 51

23. BURIAL, CREMATION, EMOVAL (Specify) Burial DATE THEREOF 1/21/51 NAME OF CEMETERY OR CREMATORY Deer Creek Methodist Cemetery LOCATION (City, town, or county) (State) Md.

DATE REC'D BY LOCAL REG. Jan. 19-1951 REGISTRAR'S SIGNATURE A. L. Lewis M.D. 24. FUNERAL DIRECTOR Pennington & Son ADDRESS Harford, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

680-916

RECEIVED
JAN 28 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0572

Reg. Dist. No. 181

1. PLACE OF DEATH- COUNTY <u>Harford</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
TOWN <u>Aberdeen</u>		TOWN <u>Aberdeen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>117 Post Road</u>	
3. NAME OF DECEASED (First) <u>Irène</u> (Middle) <u>Mary</u> (Last) <u>McPherson</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 19 1888</u>
9. AGE last birthday <u>62</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel T. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Walter B. Taylor</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause

(a) Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH

94a

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Ronald C. Palmer M.D. Deputy Medical Examiner Harford Co. Bldg. in Md. 1/15/51

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

Jan 18th 1951

Bakers Cemetery

Aberdeen, Harford, Md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 16 - 1951

Hellie B. Riley

Henry Larringer Sons Aberdeen

Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



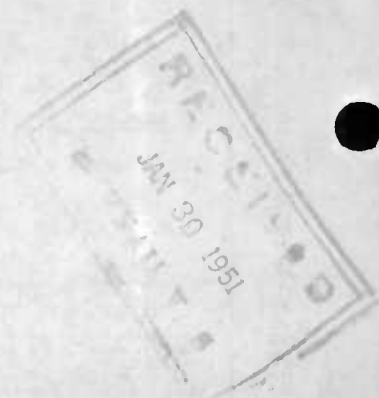
Reg. Dist. No. 780

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY <u>Howard</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OR DECEASED: STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Criswell</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Criswell</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>Bel Air R.D.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>George Howard McVey</u>		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH <u>January 23 1951</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	
8. DATE OF BIRTH <u>July 23, 1884</u>		9. AGE last birthday <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>John J. McVey</u>	
14. MOTHER'S MAIDEN NAME <u>Martha Hooper</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Wm John R. Frey, Criswell, Md</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
122.1 Immediate cause (a) <u>Arteriosclerotic CV disease</u>					
93d Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>50</u> , to <u>—</u> , 19 <u>—</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>50</u> , and that death occurred at <u>1 P</u> m., from the causes and on the date stated above.					
SIGNATURE <u>Gerald C Palmer M.D.</u>		ADDRESS <u>Bel Air, Md</u>		DATE SIGNED <u>11/23/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan. 26, 1951</u>		NAME OF CEMETERY OR CREMATORY <u>Cokesbury</u>	
LOCATION (City, town, or county) <u>Abingdon, Howard Md</u>		24. FUNERAL DIRECTOR <u>Howard R. McVey & Son</u>		ADDRESS <u>Abingdon Md 100135</u>	
DATE REC'D BY LOCAL REG. <u>Jan 26 1951</u>		REGISTRAR'S SIGNATURE <u>Marion M. Mansfield</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>JEANETTE</u> (Middle) (Last) <u>PLACE</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>29</u> (Year) <u>1951</u>	
SEX <u>Female</u>	5. COLOR OR RACE <u>White</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	7. DATE OF BIRTH <u>Dec 15, 1875-35</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chauncy Alger</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Mills</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs. E. R. Stroll</u>		18. MEDICAL CERTIFICATION <u>North East, Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
1420.1 Immediate cause (a) <u>Coronary occlusion</u>		<u>Sudden death</u>	
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Chr. Hypertensive Cardio-Vascular disease (decompensated)</u>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 13, 1951</u> , to <u>Jan 29, 1951</u> , that I last saw the deceased alive on <u>Jan 26, 1951</u> , and that death occurred at <u>5:00 P.m.</u> from the causes and on the date stated above.			
SIGNATURE <u>Willard P. Hudson, M.D.</u>		ADDRESS <u>Forest Hill Md.</u> DATE SIGNED <u>1-30-51</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb 3, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Cecil Co., Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>Jan 30, 1951</u>		REGISTRAR'S SIGNATURE <u>C. H. Kirk</u>	
24. FUNERAL DIRECTOR <u>H. D. Bailey</u>		ADDRESS <u>Baltimore Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 9 1951
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR (RURAL)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN (RURAL)</u>	
TOWN <u>HARFORD CONVALESCENT HOME</u>		TOWN <u>CHURCHVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First) <u>LAURA</u>	(Middle) <u>ROSE</u>	(Last) <u>PLUMMER</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-29-1861</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>RUTH MACOMBER, R.D. 2, ABERDEEN, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 Immediate cause (a) <u>Chr. myocardial Disease</u>		
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterio-sclerosis</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 5, 1950, to Jan 24, 1951, that I last saw the deceased alive on Jan 23, 1951, and that death occurred at 8-10 P. M. from the causes and on the date stated above.

SIGNATURE <u>Willard P. Hudson M.D.</u>	DATE THEREOF <u>1-26-1951</u>	NAME OF CEMETERY OR CREMATORY <u>CRANBERRY CEMETERY</u>	LOCATION (City, town, or county) (State) <u>FURCHES, NO. CAR.</u>
DATE REC'D BY LOCAL REG. <u>1/25/51</u>	REGISTRAR'S SIGNATURE <u>Priscilla Howard</u>	24. FUNERAL DIRECTOR <u>HENRY TARRING & SONS</u>	ADDRESS <u>Aberdeen, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 185

1. PLACE OF DEATH: COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel-air Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>John H. Price JR.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 30 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 31, 1911</u> 39 yrs.
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Manager</u>		10. KIND OF BUSINESS OR LOCATION <u>Horse & Car</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Price</u>		14. MOTHER'S MAIDEN NAME <u>Martha Amos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. John H. Price JR.</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Gunshot wound cerebrumINTERVAL BETWEEN ONSET AND DEATH
14 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home

(CITY OR TOWN)

(COUNTY)

(STATE)

Bel Air Harford Md.TIME (Month) (Day) (Year) (Hour) OF INJURY Jan 30 1951 7A m.INJURY OCCURRED While at work ☐ Nnt while at work ☒

HOW DID INJURY OCCUR?

Shot self with pistol22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion, resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald E. Palmer MD Deputy Medical Examiner Harford Co. Bel Air Md 1/30/51

23. BURIAL, CREMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial Feb 2, 1951 Harlington Cem Harford Co. Md.
Feb 1, 1951 E. H. BirkH. S. Bailey Harlington, Md.Dr. R. L. Lewis920619 Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harlington</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hosp</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>SAMUEL</u> (Middle) <u>FREDERICK</u> (Last) <u>LACINE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 27 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>JAN. 11, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Paper Maker in Papermill Cecil Co., Md.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>83</u> yrs. If under 1 year: Months Days Hours Min.
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Mrs Rosemary Thomas Harlington, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Acute Peritonitis</u>			
Antecedent cause(s) (b) <u>Perforated Gastric Uleer</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>1. 24. 51</u>		19b. MAJOR FINDINGS OF OPERATION <u>Perforated G.U. Peritonitis</u>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		20. AUTOPSY? <u>Yes</u> <input checked="" type="checkbox"/> No <input type="checkbox"/>	
PLACE (Home, farm, factory, street, OF INJURY)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1. 24</u> , 19 <u>51</u> , to <u>1. 27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1. 27</u> , 19 <u>51</u> , and that death occurred at <u>11:18 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Alexander Sandeek</u>		DATE SIGNED <u>1. 27. 51</u>	
(Degree or title) <u>M.D.</u>		ADDRESS <u>Harre de Grace, Md</u>	
23. BURIAL OR CREMATION (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Harlington Cem.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Jan 27-1951</u>		LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
24. FUNERAL DIRECTOR <u>A. S. Bailey</u>		ADDRESS <u>Harlington, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

690456



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

0578

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Belcamp</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Belcamp Md.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>CATHERINE S. Repp.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 2 1951</u>		
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr 10, 1885</u>
9. AGE last birthday <u>65</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEONHARD Repp</u>		14. MOTHER'S MAIDEN NAME <u>MARY STUMPFNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If year, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY No. <u>NO</u>	
17. INFORMANT AND ADDRESS <u>TILLIE ZUKOWSKI.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>7 days</u>
Antecedent cause(s) (b) <u>Intestinal obstruction {low grade} cause not known?</u>		<u>14 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senile Psychosis</u>		<u>2 year</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1949, to Jan 2, 1951, that I last saw the deceased alive on Jan 2, 1951, and that death occurred at 8:30 A.m., from the causes and on the date stated above.

SIGNATURE Jed O Hodous M.D. ADDRESS Edgewood Md DATE SIGNED Jan 251

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>1/4/51</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>	LOCATION (City, town, or county) (State) <u>O'Donnell St. Balt. Md</u>
DATE REC'D BY LOCAL REG. <u>3-50</u>	REGISTRAR'S SIGNATURE <u>H.W. Fredrick</u>	24. FUNERAL DIRECTOR <u>Mildred J. Blight</u>	ADDRESS <u>6009 Harford Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Harford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> TOWN <i>Harford</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i> TOWN <i>Chesapeake</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial</i>		STREET ADDRESS (If rural, give location) <i>103 A-Westgate Gardens</i>	
3. NAME OF DECEASED (Type or Print) <i>Donna Marie Roberto</i>		4. DATE OF DEATH (Month) <i>January</i> (Day) <i>17</i> (Year) <i>1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>January 16, 1951</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>17</i> yrs. If under 1 year Months <i>1</i> Days <i>1</i> If under 24 hrs. Hours <i>1</i> Min.
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William D. Roberto</i>		14. MOTHER'S MAIDEN NAME <i>Beatha Elia-</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No. <i>103 A-Westgate Gardens</i>	
17. INFORMANT AND ADDRESS <i>Hospital Records</i>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased

alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

20 1161222 405



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

Evidence for addition
in #8 & #9 shown on:

FUM No. G 130 FEB 9 1951

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

0580

182

1. PLACE OF DEATH- COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>Hartford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Vernon Winfield Scarff</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 28, 1903</u>
9. AGE last birthday <u>47</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Fallston Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Winfield Scarff</u>		14. MOTHER'S MAIDEN NAME <u>Georgia Amos</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>Miss Basic Scarff, Fort Hill Md</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

976x Immediate cause

(a) Gun-shot wound cerebrum

INTERVAL BETWEEN ONSET AND DEATH

none

Antecedent cause(s)

164c Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS

PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.)

INJURY Home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Jan 20 1951 6P m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Shot self with shot gun

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald C Palmer MD Deputy Medical Examiner Hartford Co. Bel Air Md 11/30/51

23. BURIAL, CREMATION

REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

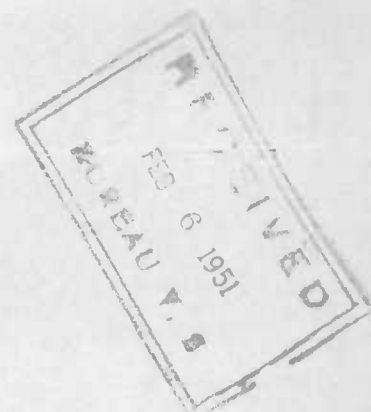
DATE REC'D BY LOCAL REG. 2-1-51

REGISTRAR'S SIGNATURE Guiscilla Lowwood

24. FUNERAL DIRECTOR Marion E. Smith

ADDRESS

820105



MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change in #9 shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0581

CERTIFICATE OF DEATH

Reg. Dist. No. *22*

HAM NO. G 1-1 MAR 1 1951

1. PLACE OF DEATH COUNTY <u>Harford</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Cecil</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bel Air</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Colona Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Convalescent Home</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (First) <u>Georgia</u> (Middle) <u>Annie</u> (Last) <u>Smeltzer</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2-28-1865</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic work</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	9. AGE last birthday <u>85</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. BIRTHPLACE (State or foreign country) <u>Md</u>		11. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
12. FATHER'S NAME <u>Charles Smeltzer</u>		13. MOTHER'S MAIDEN NAME <u>Lydia Jane Rogers</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		15. SOCIAL SECURITY NO. <u>Warren McKeever, Port Deposit, Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden death</u>
(a) <u>Coronary Embolism</u>		
Immediate cause	(b) <u>Auricular Fibrillation</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Chr. Cardio-vascular Disease</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Feb. 22, 1950, to Jan. 30, 1951, that I last saw the deceased alive on Jan. 26, 1951, and that death occurred at 11:30 a m., from the causes and on the date stated above.

SIGNATURE Willard P. Hudson, M.D. (Degree or title) ADDRESS Forest Hill, Md. DATE SIGNED 1-30-51

23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-1-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Arbary</u>	LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
DATE REC'D BY LOCAL REG. <u>Feb. 23, 1951</u>	REGISTRAR'S SIGNATURE <u>Marilla Bonwood</u>	24. FUNERAL DIRECTOR <u>Lea A. Patterson & Son</u>	ADDRESS <u>Arbary, Md.</u>

R.S.C. - NY - D
FEB 28 1961
BUREAU 7.8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harvick Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Harvick Grace</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>313 S. Freedom Alley</u>		STREET ADDRESS (If rural give location) <u>313 S. Freedom Alley</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harriett</u> (Middle) <u>Marie</u> (Last) <u>Standbury</u>	4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>7</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 25, 1868</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>82 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Prince Standbury</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT <u>Mr. Vernon Standbury</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a)	<u>Bilateral Hypostatic Pneumonia</u>	<u>2 days</u>
Antecedent cause(s) (b)	<u>Cerebral Thrombosis</u>	<u>1 week</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	<u>Arteriosclerosis Generalized</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/27, 1950, to Jan 7, 1951, that I last saw the deceased alive on Jan 7, 1951, and that death occurred at 4 A. m., from the causes and on the date stated above.

SIGNATURE <u>Arthur H. Wachsmann M.D.</u>	ADDRESS <u>Harvick Grace Md.</u>	DATE SIGNED <u>Jan. 9, 1951</u>
23. BURIAL, CREMATION (Specify) <u>Burial</u>	DATE <u>Jan. 10, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>St. James</u>
LOCATION (City, town, or county) <u>Harvick Grace Md.</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Jan. 10 - 1951</u>	24. FUNERAL DIRECTOR <u>A. A. Lewis M.D.</u>	ADDRESS <u>St. Madison Mitchell Harvick Grace Md.</u>

720 826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 12 1951
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bell Air</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bell Air Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Co Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Wm</u>	(Middle)	(Last) <u>STROTHER</u>
4. DATE OF DEATH	(Month) <u>Jan</u>	(Day) <u>20</u>	(Year) <u>1951</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1868</u>
9. AGE last birthday <u>83</u> yrs.		If under 1 year: Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Ontario Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Americans</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-126041</u>	
17. INFORMANT AND ADDRESS <u>El Rey Farm</u>		<u>Charles S. Somanus Kingsville Md</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>443x Immediate cause Cerebral Hemorrhage</u>			<u>7 da</u>
(b) <u>93d Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			<u>Chx/Hypertensive Cardio-Vascular Disease ?</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 15, 1951</u> , to <u>Jan 20, 1951</u> , that I last saw the deceased alive on <u>Jan 18, 1951</u> , and that death occurred at <u>12:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>William P. Hudson, M.D.</u>		ADDRESS <u>Forest Hill Md</u>	
DATE SIGNED <u>1/20/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan 22/51</u>	
NAME OF CEMETERY OR CREMATORY <u>St John</u>		LOCATION (City, town, or county) (State) <u>Bel Air Md</u>	
24. FUNERAL DIRECTOR <u>Joseph Foster</u>		ADDRESS <u>Bel Air Md</u>	

690 859

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Fleury</u> (First) <u>Y.</u> (Middle) <u>Sullivan</u> (Last)		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>1</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 6, 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegrapher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	9. AGE last birthday <u>80</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Edgewood, Harford Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas J. Sullivan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Lynch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>705-07-9922</u>	
17. INFORMANT AND ADDRESS <u>Elizabeth J. Sullivan, Edgewood Md</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>			<u>9 days</u>
420. Antecedent cause(s) (b) <u>arterial sclerotic heart disease</u>			<u>10 years</u>
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from Dec 24, 1950, to Jan 1, 1951, that I last saw the deceased alive on Jan 1, 1951, and that death occurred at 8:15 P.M., from the causes and on the date stated above.

SIGNATURE Fred O. Hodous M.D. ADDRESS Edgewood, Md. DATE SIGNED 12-51

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE Jan 4, 1951 NAME OF CEMETERY OR CREMATORY St. Francis LOCATION (City, town, or county) (State) Abingdon, Harford, Md

DATE REC'D BY LOCAL REG. Jan 4, 1951 REGISTRAR'S SIGNATURE Maureen M. Mondsack 24. FUNERAL DIRECTOR Howard H. Mc Cormack Son ADDRESS Abingdon Md 640506

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 10 1951
U.S. AIR FORCE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pylesville, Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pylesville, Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>ELLA</u> <u>MAY</u> <u>TURNER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan.</u> <u>6</u> - <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>May 20-1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>80</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Leight</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Krah</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Edward Turner - Whiteford Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Carcinoma of colon</u>		
153X Antecedent cause(s) (b) <u>none</u>		
46e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>none</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1....., 1950., to Jan 6....., 1951., that I last saw the deceased alive on Jan 4....., 1951., and that death occurred at 12 30 a.m., from the causes and on the date stated above.

SIGNATURE <u>Charles C. Hoff Md.</u>		ADDRESS <u>Street, Md.</u>		DATE SIGNED <u>Jan 8, 1951</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>Jan. 9-1951</u>	NAME OF CEMETERY OR CREMATORY <u>Highland cemetery</u>	LOCATION (City, town, or county) <u>Street,</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1/8/51</u>	REGISTRAR'S SIGNATURE <u>Willa Towood</u>	24. FUNERAL DIRECTOR <u>Hubert P. Harkins, Delta, Pa.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 12 1951
BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0588

1. PLACE OF DEATH:

County Hanover
City or town Fork
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years 6 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Hanover
City or town Fork
(If outside city or town limits, write RURAL and give nearest town)
Street No. Old Hanover Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Marcella Twardawicz

3. (b) Social Security Number

216-03-3341

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Frank Twardawicz

7. Birth date of deceased (mo., day, yr.) 1892 6.(c) If alive, give age 18 years

8. AGE: Years 18 Months 5 Days 1 If less than one day hrs. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name Szechawski

13. Birthplace Poland

14. Maiden name Laskowski

15. Birthplace Poland

16. Informant Miss Jean Twardawicz Daughter

Address Fork Md. Hanover County

17. Burial Date thereof Jan 18 1951
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Rosary

Location Baltimore County

18. Funeral director John M. Weber

Address 401 S. Chester Street Balto Md

19. 1-16-51 (Date rec'd by registrar) Registrar C

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 14 1951 at 2P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1938 to Jan 14 1951 and that I last saw her alive on Jan 14 1951

Immediate cause of death Acute Pulmonary DURATION 12 hrs

Edema Due to Coronary Thrombosis 24 hrs

Hypertensive Cardiac Due to Vascular Disease ?

Other conditions Diabetes ?

42A Pneumonia (Include pregnancy within 3 months of death)

Major findings of operations 61

Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Efford F. Hudson MD M. D. of other

Address Fork Md Date signed 1/15/51

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

0587
 Reg. Dist. No. 181

1. PLACE OF DEATH- COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Del.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Abertown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lake Forest</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>89 W. Waukegan Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>William</u> (Middle) <u>J</u> (Last) <u>Weber</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>4</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Apr. 24 1928</u>
9. AGE last birthday <u>22</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Soldier</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Army</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William C. Weber</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>current</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT <u>Records, Abertown Prov. ground</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Decerebration

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

complete destruction body into small parts

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Jan 4 1950 7:00 pm.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Stuffed in front of train

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Gerald C. Palmer M.D. Deputy Medical Examiner Harford Co. B.D.A. and 1/5/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Removal

Jan 8, 1951

Weyman Funeral Home

Lake Forest, Del

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 12 - 1951

William E. Riley

Howard R. Mc Cormack Sr

Abertown Maryland 595116.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 15 1951
B. A. B. B. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>NAVY DE GRACE</u> TOWN <u>NAVY DE GRACE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harford Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Md.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>NAVY DE GRACE</u> TOWN <u>NAVY DE GRACE</u> STREET ADDRESS <u>316 St. John St</u> (If rural, give location) <u>Md.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Hugh</u>	(Middle) <u>Alexander</u>	(Last) <u>West</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 11, 1880</u>
9. AGE last birthday <u>70</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Pake West</u>	
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>212-05-0707</u>	
16. SOCIAL SECURITY No. <u>212-05-0707</u>		17. INFORMANT AND ADDRESS <u>Wm. Martin West</u>	

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 Immediate cause (a) <u>Arteriosclerosis</u>			
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Coronary Arteriosclerosis</u>			
(c) <u>Chronic Myocarditis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June 19, 1950, to June 20, 1950, that I last saw the deceased alive on Jan 20, 1951, and that death occurred at 7:35 a.m., from the causes and on the date stated above.

SIGNATURE Charles J. Foley M.D. ADDRESS 400 S. N. Union Ave DATE SIGNED 1/20/50
(Degree or title) MD

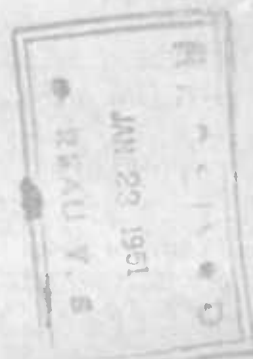
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 23, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Run</u>	LOCATION (City, town, or county) <u>Harford</u> (State) <u>Md.</u>
DATE REC'D BY LOCAL REG <u>Jan 21-1951</u>	REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	24. FUNERAL DIRECTOR <u>H. Madison Mitchell</u>	ADDRESS <u>Harford Md.</u>

570378 Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <u>HARFORD</u> <u>Memorial Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CECIL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>HARVE DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PORT DEPOSIT</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD Memorial Hosp</u>		STREET ADDRESS (If rural, give location) <u>PORT DEPOSIT</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>HADDIE</u>	<u>T</u>	<u>WILLIAMS</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>Jan. 20</u>	<u>1951</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1864-July 27</u>
			9. AGE last birthday <u>86</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired housewife own home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>County Cecil, Md</u>
13. FATHER'S NAME <u>Joseph England</u>		14. MOTHER'S MAIDEN NAME <u>Elyse Marie Grant</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Clarence Williams Charlestown Md</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Thrombotic Embolism

INTERVAL BETWEEN ONSET AND DEATH

40 hrs

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Obstetrical Resection for obstruction

6 days

(c) Heart Failure, Sinus & Chronic Hypertension

10 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

Intestinal Obstruction

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY

INJURY OCCURRED
While at Work ☐ Not While at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 19, 1947, to Jan. 19, 1951, that I last saw the deceased

alive on Jan. 19, 1951, and that death occurred at 10:20 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.
Jan. 20-51

REGISTRAR'S SIGNATURE
G. L. Lewis M.D.

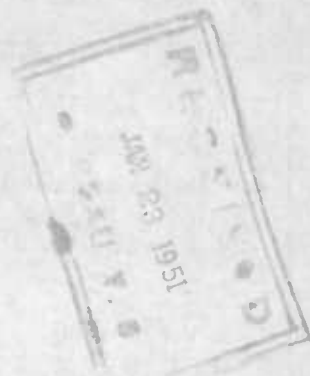
24. FUNERAL DIRECTOR
J. E. Tyson

ADDRESS
Reisterstown Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

0590

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace Rural</u>	
TOWN <u>Harford Grace Rural</u>		TOWN <u>Harford Grace Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Nozel</u> (Middle) <u>Virginia</u> (Last) <u>Wood</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 10 - 1896</u>
9. AGE last birthday <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel Callum</u>		14. MOTHER'S MAIDEN NAME <u>Effie Gray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Harrison W. Wood</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

352x Immediate cause

(a)

Hemiplegia

Antecedent cause(s)

83d

Disease or condition(s), if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS
 Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

none

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dwight C Palmer M.D. Deputy Medical Examiner Harford Co. Bldg.

11/15/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan. 16 - 51 Mellie H. Wiley

Henry Tarring & Sons Aberdeen Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition MARYLAND STATE DEPARTMENT OF HEALTH
in #18 shown on:

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 183

FILM No. G 130 JAN 29 1951

1. PLACE OF DEATH- COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>HAURE DE GRACE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>HAURE DE GRACE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HARFORD MEMORIAL HOSP.</u>		STREET ADDRESS (If rural, give location) <u>362 Bourbon</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Julia</u>	(Middle)	(Last) <u>Wood</u>
4. DATE OF DEATH	(Month) <u>JANUARY</u>	(Day) <u>9</u>	(Year) <u>1951</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>10/28/1867</u>
9. AGE last birthday <u>83</u> yrs.	If under 1 year Months <u>2</u> Days <u>12</u>	If under 24 hrs. Hours <u>12</u> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>
11. BIRTHPLACE (State or foreign country) <u>France de France</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>John DePaul</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT AND ADDRESS <u>362 Bourbon St. Mrs Robert Wood France de France</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153x Immediate cause

Antecedent cause(s)

462 Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(a)

(b)

(c)

Generalized carcinoma.
Pathological fracture of hip.

Carcinoma of the colon is the most probable primary site

(1/2/51 arc)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from DEC. 23, 1950, to JAN. 9, 1951, that I last saw the deceased alive on JAN. 9, 1951, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial
1/13/51
Angel Hill
France de France, Md.
JAN. 13-51
G. L. Lewis M.D.
Funeral Director
France de France, Md.

